



HEMATOPOIETIC AGENTS



New Hampshire

NH Medicaid Prior Authorization Request Form

Fax: 1-888-603-7696 Phone: 1-866-675-7755

Date of Medication Request: ____/____/____

Section I: Patient Information and Medication Requested:

Name: (Last, First) _____	NH Medicaid Number: _____
Date of Birth: ____/____/____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Drug Name: _____	Strength: _____
Dosing Directions: _____	Length of Therapy: _____

Section II: Clinical History:

1. What is the condition that this medication is being prescribed for? _____

Or select all that apply:

- | | |
|---|---|
| <input type="checkbox"/> anemia associated with chronic kidney disease | <input type="checkbox"/> patient is on dialysis or is predialysis |
| <input type="checkbox"/> anemia associated with cancer chemotherapy | <input type="checkbox"/> anemia associated with prior chemotherapy |
| <input type="checkbox"/> anemia in HIV infected patient treated with AZT | <input type="checkbox"/> anemia in myelodysplastic syndromes (MDS) |
| <input type="checkbox"/> patient with Hepatitis C on ribavirin | <input type="checkbox"/> anemia in lymphoproliferative disorder |
| <input type="checkbox"/> anemia associated with current radiation therapy | <input type="checkbox"/> anemia associated with prior radiation therapy |
| <input type="checkbox"/> anemia associated with malignancy | |

REQUIRED LAB RESULTS

- What is the patient's current hematocrit and hemoglobin level? _____
- What is the patient's baseline hematocrit and hemoglobin level? _____
- What is the patient's target hematocrit and hemoglobin level? _____
- What is the patient's current transferrin saturation and ferritin level? _____
- Is there a plan for decreasing dose or discontinuing medication once patient has achieved goal? Please describe. _____

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

Section III: Prescriber Information:

Print Name: _____	DEA Number: _____
	NPI Number: _____
Phone Number: (____) _____ - _____	Fax Number: (____) _____ - _____

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Prescribing Provider